Doctor to patient, doctor to colleague: the ethics of medical practice

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We were invited to speak at a medical conference on Kauai: "Kauai Calls: People caring for people" held at the Kauai Hilton 21 to 25 February 1991. It was presented by the Society of General Practitioners, the British Columbia Medical Association and the BC Chapter of the College of Family Physicians, all of Canada, together with and by special invitation from the Department of CME of Wilcox Memorial Hospital and the Kauai County Medical Society. David Elpern MD and Paul Esaki MD, of Lihue and Kapaa respectively, were the local sparkplugs and organizers.

The *New Patriot*, a Chicago publication edited by John Rossen, in its April 1990 issue had this to say in an editorial entitled, "Ethics and a Sense of National Purpose," and we quote:

> "The 1990s have been a decade of spiritual and moral crisis for our nation. Dominated by a national administration arguably the most corrupt and scandal-ridden in our history, our society has been transformed into a moral jungle, devoid of any sense of national purpose. Public and private deceit, graft and corruption have become endemic in the White House, in the two houses of Congress, in Wall Street and at every level of government, business and commerce.
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> "Cynicism engulfs the nation, and fewer than 50% of eligible Americans bother to participate in the heart of the democratic process: The electoral system. The high democratic ideals of the American Revolution, which today are moving hundreds of millions of people around the world into political struggles for democracy, are trampled on, forgotten and neglected in our own country. Fifty percent of our high school students are unable to identify the text of the Declaration of Independence or the Bill of Rights."

Having quoted this provocative statement, and stirred up your endocrine juices, please allow me to get on to the subject at hand — ethics in general, and then, professional medical ethics.

Humanitarianism is the basis for ethics, which govern all interpersonal relationships. It is defined (in my Funk and Wagnalls dictionary) as "the doctrine, principles and practices of one who holds that man's duty is limited to right-doing toward others and has an interest in the public welfare." (Notably, this is in contrast to the word "humanism," which the dictionary defines as a system of thinking in which man, his interests and his development are made central and dominant; eg a humanist.)

As to professional ethics, the American Academy of Family Physicians (AAFP), in its *Ethical Principles in the Physician-Patient Relationship*, I think states it best, and I quote from it freely:

> "The fundamental physician-patient relationship is a voluntary, humanitarian association between two or more people who are joined by the desire to solve a health problem. The moral characteristics of this association are firmly based on humanitarianism.
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> "The bond between doctor and patient normally comprises more than a formal contract can express.
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> "The humanitarian impulse is the foundation of the 'exemplary professions' which include medicine, law, teaching and the clergy. These, and related professions, are distinguished from other occupations by their devotion to a moral code which sets humanitarianism above other considerations.
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> "Not all people possess humanitarianism in equal degree. In some, its influence is compelling; in others slight. It can become subordinated to other desires or even extinguished. It conflicts with other natural drives, including the instincts to acquire property, to dominate others and to be autonomous. Humanitarianism causes people to set aside their natural tendencies to be suspicious and self-protective, to exploit weaknesses in others, and to withdraw from pain and suffering.
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> "Some understandings of western democratic capitalism contain the abstract notion that 'the market' is the underlying mechanism enabling every function in society. In this extreme view, 'market forces' are necessary and sufficient to provide for all society's needs. Under this formulation, humanitarianism is merely an inciden-

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tal sentiment. It can be analyzed and exploited, but it is irrelevant to the process of governing an organization or a political entity.

"While it is possible to imagine physicians, lawyers, teachers and ministers under such a philosophy, this vision is morally handicapped. In order to serve honorably and effectively, the exemplary professions require a bond of trust between providers and recipients that is unobtainable in the absence of bona fide humanitarianism. A purely mercantile system can never encompass the motives these professions require to operate responsibly.

"Humanitarianism is necessary for the existence of a moral physician-patient relationship. The desire to help lies at the foundation of medicine. It does not merely sweeten it. At the same time, bilateral ethical obligations between the patient and his physician, that go beyond any technical, commercial or legal considerations that also operate, are created by the moral nature of the medical relationship."

Professional ethics

Professional ethics are designed to provide principles that represent goals to which physicians (in our case) should and can aspire in our treatment of patients. The corollary is also important: That patients deal honestly with their physicians, but we, as physicians under a moral code that should govern us, do not have the right nor the privilege to demand that our patients adhere to our code of ethics.

So — how does one deal best with the usual, customary and reasonable —

PATIENT?

The AMA has spelled out just 7 general principles. In the preamble, it states: "The medical profession has long subscribed to a body of ethical statements developed *primarily for the benefit of the patient.*" In none of these does it mention anything about the ethical conduct of the patient.

The AAFP, on the other hand, devotes a whole section to:

"Truthfulness"

in which it expounds at length on the obligations of the patient. With this I do not agree; it is unenforceable. I am certain that many of you have had experiences similar to mine, in which the patient comes close to doing himself harm by being afraid of doing something he considers to be unethical, such as not wanting to dissociate himself from a previous physician in whom he no longer has confidence. Patients are often afraid of compromising their own best interests by perhaps breaking an inviolate code of medical ethics, and say so.

The AAFP's initial statement, however, is a good one: *"The physician and the patient both owe each other the truth."* So is a following statement: "Physicians must make their patients partners in the medical thought process." In this day and age of widespread education of things medical via the sight and sound media, patients are much more critical — critical in the sense of being understanding and perceptive, able to reason carefully and seriously — despite our proclivity to use medical jargon, often inadvertently, that confuses the most intelligent of them. I am certain that most of you relish the intelligent patient who can follow the oftentimes devious and difficult algorithm of a complicated case.

On the contrary, we physicians are often too impatient with the smart aleck who challenges everything we say, or who quotes all the latest scare articles in newspapers and magazines, or the latest wild commercials that pervert the truth. Such patients, of course, challenge us to be extra careful and patient with the words we use and the meanings we convey.

We must remember, particularly, that the greater failure in communicating with the patient lies in our failing to ask the right questions, more even than in failing to listen perceptively.

The AAFP's *Ethical Principles* goes on at great length in this section; it is well worth your while to refer to them, and frequently.

However, I need to tell you that I have a particular, personal ethic when it comes to the subject of *Confidentiality and Documentation* in this same AAFP section. So does the AMA's *Current Opinions* by its Council on Ethical and Judicial Affairs go into great detail on the issue.

Some of us document extensively; others, very little. Sometimes I wonder that the hieroglyphics and the abbreviations penned on paper are meant to obfuscate colleagues, lawyers and patients alike! It has been said that if nothing is documented — ie it remains encapsulated only in the physician's noggin — confidentiality is preserved absolutely. However, the legal profession frowns on that concept and defense attorneys warn of dire consequences for the physician who has been sued for malpractice.

It is my contention that what a physician documents about his patient is absolutely inviolate and confidential and is — the physician's — personal property. It does not belong to the patient. It is an extension of the physician's thoughts, a memorandum to himself, his "paper brains" as it were. Lawyers, insurance people, the patient and others have the right to seek the necessary information from the physician, but it is up to the latter, after safeguards as to confidentiality, to divulge the necessary data as he sees fit and if it is appropriate, *unless the patient gives the physician carte blanche to do so and reveal everything in the patient's best interest.*

I cite you the case of our own Kauai colleague, who a year or so ago, was forced to release confidential data under the threat of imprisonment with consequent damage to his practice, his bread-winning, his family and himself. I think that was very wrong. I have often dreamed of ways to thwart that kind of tyranny; fortunately, I have never had an instance in my practice that required that, although I must admit that I have means of prevaricating when I document! Once again I say: We physicians should stand up for this basic right. It is an unwritten ethic that we should not have given up.

When you come right down to it, the physician's conscience should be his guide. However, the apprentice-physician needs to study the ethics of medicine as much as he must study the substance of the technique and the art. The foundation of it lies in *primum non nocere,* as it concerns the patient.

The ethics of how a physician should deal with his patient is much more complicated than this brief treatise intimates; I hope it whets your appetite to research it at greater length and to satisfy your interest in the subject. The extended lifetime of personal experience in the practice of medicine will teach you more than "book larnin'" will. Every patient of yours will teach you something new, provided that you are willing to learn. Physicians are physicians primarily because they are intensely interested and curious people and delight in probing into the innermost recesses of another human being. This cannot be done satisfactorily without a high degree of awareness of the vagaries of interpersonal relationships. This is not peculiar to the profession — life on this planet cannot proceed without such awareness and the response that is necessary to go along with that awareness — but it is particularly important in the case of the doctor-patient relationship.

That said, let us delve into the ethical relationship with a —

COLLEAGUE.

Again, the key word is proper *communication.*

The problems of relationships between physicians are legion; you will excuse me, I hope, if I limit my remarks to only some of them.

The one aspect in particular that I want to address is the matter of consultations. But before going into that topic, I need to present to you the AMA's Article II of its *Principles of Medical Ethics:* "A physician shall deal honestly with patients and colleagues ..." That phrase cannot be challenged; however, the rest of it bothers me as much as it must bother you, if not all. I repeat: "A physician shall deal honestly with the patients and colleagues" comma, "and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception."

The one saving grace in the last phrase is the word strive — "*strive* to expose." It doesn't simply mandate "to expose," but to strive to do so.

Are we to be informers? Are we to emulate the pre-Perestroika Soviet Union? Ie the USSR under the KGB, in which every citizen had to keep his opinions, and even his thoughts, to himself, even in the presence of his close friends, for fear of being reported as a subversive?

On the other hand, it is our duty as an honorable profession and in our stated role as protectors of our patients, to maintain standards of professionalism and competence within our own ranks.

I think this poses a real conflict in ethical conduct. We have solved it in the peer review process by rules and regulations that govern conflict of interest, that are designed to eliminate the interjection of malice and that allow the accused due process. Ninety-nine percent of the time this process works well.

But, before it comes to that stage of proceedings, there is the interpersonal dilemma in which any one of you, or I, sense a failing in a colleague and are torn between our sympathy, our concern, and our duty. In such an instance, we must straighten up and remember that *the welfare of the patient comes first,* and let the chips fall where they may.

The simple answer perhaps — in considering this important issue all too briefly — is to gird up one's courage and approach the colleague directly and privately, and with friendly sincerity accost him with your concern. If his response meets you halfway, the road ahead might be smooth.

If, on the other hand, his response is to bristle and deny, a word to him that you feel you must quietly bring it up to a small, select committee of his peers, may alert him to the seriousness of the problem and bring him around.

In other words, a compassionate informer is far different from the malicious informer in the reference given above. Perhaps the AMA's Article II should substitute for the word "expose" a phrase along the lines of "strive to bring those physician colleagues ... into the intra-professional remedial effort and then allow that entity to proceed further to refer that recalcitrant colleague to the legal system if it becomes necessary."

As you all know, the profession is being accused of "honor amongst thieves" and "shielding the bad apples," whereas, in fact, we find it difficult in the extreme to cope with such miscreants when they call in the legal beagles to assist them in suing the peer reviewers on the grounds of malice, conflicts of interest, etc!

Consultations

I am in general practice, which is the old way of saying family practice. Most of you, I think, are certified in Family Practice. In watching the development of the certification process in Family Practice, I see it as combining the specialties of Internal Medicine and Pediatrics. In the United States of America, the premiums demanded in order to obtain insurance against malpractice have made the delivering of babies nearly impossible for FPs.

The same can be said about doing surgery, except that the main reason FPs are precluded from doing major surgery is because surgeons rightfully feel that the training required naturally leads to intensive specialization. An FP half-trained in surgery is not a surgeon — unless he establishes himself far out in an isolated community where the nearest board surgeon is miles away.

Anyway, I speak as an old generalist who, 52 years ago, did deliver babies, even by C-section and did major surgery, even by flashlight when the power failed on occasion; up until the plethora of highly competent specialists came into town.

In short, an FP is not a generalist. However, be that as it may, we have a common problem, which is that the patient of a primary care physician, when referred to a specialist is likely to be set adrift in the turbulent waters of organ-oriented medicine. It is the patient — the whole person — who becomes disoriented and confused when he finds himself in a maelstrom of strange faces, strange places, strange technology. The anchor of a personal physician is no longer holding the patient's boat steady. He signs informed consent papers when asked to. He is afraid not to. He is afraid, period. He latches onto one nurse at a time, hoping she will stay long enough on his case to be a reliability, a source of comfort and assurance that all will be well.

All this is our fault — we physicians. As a rationalization,

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we hide behind the screen of technocracy — to cover our okoles (as we say in Hawaiian). Is there an infection? Quick, call in the infection specialist. Is the CBC abnormal? Quick, call for an invasive bone marrow biopsy and a hematologist.

The specialist of today — nay, even the primary physician — is often too prone to order more tests, or to pass the poor patient on down the line to others, instead of having the patience to let nature take its course in the way of the body healing itself, in the way of giving it time to do so.

Much of this is generated by the public — by the patient or his family. However, that may be a reflection of the anxiety of those lay people affected and an indication that we physicians show too much indecision and anxiety ourselves; we have probably not established the foundation of trust needed in the doctor-patient relationship.

We need some guidelines — a dose of ethics — in the way we physicians deal with each other in caring for such a patient.

I say that we desperately need to establish a better system, an ethical one, in which the patient's personal physician, the old PMD — Personal Medical Doctor — be invited, encouraged and properly reimbursed for his personal service to and advocacy on behalf of the patient — to attend him all the way up the line. The specialist to whom the patient is referred by the PMD should never ethically refer the patient to any other physician without informing the PMD *and* obtaining his consent first (except in a dire emergency or except in the instance of the PMD being immediately unavailable).

It is our patient who needs this. I can recount tale after tale of cases in which the patient has actually been mistreated, inadvertently to be sure, by our present system wherein the specialist assumes total control by placing *your* patient on a conveyor belt to God knows where and unattended by you, his PMD.

It is the FP, in your case, who knows the patient best of all, who knows his family, his milieu, his work, his community as well as his temperament and his phobias. It is his FP — his PMD — who can succor him as he travels that conveyor belt to somewhere definitive (a side-benefit would be many less malpractice suits!).

As a horrible side issue of this same problem in good patient care, the patient referred to hospital-based physicians all too often is referred back to the PMD with nary a word, written or spoken, as to what happened in-hospital; the patient may call or visit his PMD unprepared. Mostly he doesn't bring his discharge meds, and all he can relate is "them thar pink pills make me sick." Hardly ever does he bring a sheet of paper upon which the nurse has written doctor's orders, sometimes in the way she would transcribe them from the hospital chart — in medicalese, totally unintelligible to a lay person. Most of the time that piece of paper is attached to the hospital bill, which the patient is afraid to scan for fear of precipitating a heart attack! He never brings the bill to have his PMD review its contents that are in Greek and Sanskrit, for veracity!

The hospital summary? Well, you might receive one if the consultant number one, not to speak of down the line consultant number 10, remembers that you were the original PMD and needed the summary for continuing care of that patient.

The patient would tend to gravitate back to his PMD in nearly all cases; but consultant number one or number 10 has probably given the patient an appointment to return to see the consultant, of whom the patient has a vague recollection and in whom the patient has an unsecured confidence.

In wartime in the military services, the patient's record accompanies the patient's body. Continuity of communication is established and maintained; is there any reason why we cannot do the same in civilian life?

The ethics of physician-to-physician demands it.

The 7 principles defined by the AMA can really be boiled down to an essential 3: (1) The ethical principles by which a physician deals with his patient; (2) how he interacts with his colleagues and (3) his obligations to his community, ie his social obligations to humankind.

I have touched on bits and pieces of the first two categories. I discussed a personal response to the third at the "Seaside Chats" yesterday afternoon: The physician's obligation to watch over the health of his community — including the larger community of the whole planet. This is indeed an "ethos" that he needs to adopt.

Ethos is derived from the Greek word meaning "character"; it is defined as:

(a) The standard of character set up by any race or nation;

(b) the study and philosophy of human conduct, with emphasis on the determination of right and wrong; and

(c) the basic principles of right action (as stated in Funk and Wagnalls).

This applies to all citizens of the world. However, the physician being as he is, educated and trained in the ways of man's body and mind, has a particular obligation — or ethical duty — to apply his intellect to the welfare and health of all humankind.

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INSCRUTABLE
(Asian Eyelids)

Gentle lines of subtle grace
Define the lids on the Asian face
Delicate enigma — feelings concealed
Imponderable windows, with shutters part sealed.

Guarded sweetness, softly veiled
With canopied corners that never have failed
To hint at mystery and whisper clues
Of ancient culture's considered sage views.

An elegant tilt in shy downward glance
Stirs in the viewer a window of chance
To penetrate through to a lid-shielded soul
Where poorly planned surgery would take a huge toll.

Lightly inquisitive, wrinkling the brow,
Inviting an entrance that lids scant allow.
Exquisite design in human clay —
Pleading with surgeons to keep it that way!

Robert S. Flowers MD